The Mandometer® Clinics Self referral

Fill in the form as carefully as possible and send to: **AB Mando, Box 4006, S-141 04 Huddinge, SWEDEN**

We will contact you after your application has been assessed.

Please note: Submission of the Application Form doesn't automatically lead to admission to the Mandometer® program.
If you need to get in touch with us quickly, please call: +46 (0)8 556 406 00.

Name:	Today's date:
Age: ☐ Female ☐ Male	Social Security No:

Phone	Home:	Work:	Cell Phone:
Address	Street:	Zip Code:	City:
E-mail:			

Insurance Company:	
Name of your Physician:	Phone:

If you are less than 18 years old:

Name of parent/guardian:	Phone:
Name of parent/guardian:	Phone:

1. How tall are you? _____ cm.

2. How much do you weigh? _____ kg. BMI: _____ kg/m² *We will help you calculate this number*

3. Have you been losing weight during the last month?

☐ *no*

☐ *yes. How much?* _____

4. Do you think that you are overweight even though your family and friends think that you are not?

☐ *no* ☐ *yes*

5. Do you have physical problems due to your eating disorder?

☐ *no*

☐ *yes:* _____

Self referral, The Mandometer® Clinics, continued

6. If you are female; do you menstruate?

- ☐ yes, *regularly*
- ☐ *yes, but irregularly*
- ☐ *no, my periods have ceased*
- ☐ *no, I am pregnant*
- ☐ *no, I never had a period*

7. Do you regularly take any medicine(s)?

- ☐ *no*
- ☐ *yes:* _____

8. What is your resting pulse: _____ beats/minute

(sit/or lie down for ten minutes, take your pulse using finger pressure just above your thumb and look at your watch to measure time at the same time)

9. How many minutes a day are you physically active (running, walking, workout)?

_____ minutes

10. Did you have a serious "life event" (for example divorce, death) last year?

- ☐ *no*
- ☐ *yes:* _____

11. What is your desired weight? _____ kg.

12. How long have you had problems with eating?

_____

13. What does your normal eating pattern look like?

- ☐ *eating regularly*
- ☐ *restrained eating (restricting food intake to achieve weight loss or to prevent weight gain)*
- ☐ *starvation*
- ☐ *starvation alternating with restrained eating*
- ☐ *binge-eating (fast and uncontrolled consumption of large amounts of food) in periods and restrictive eating/dieting in between*
- ☐ *binge-eating daily or almost daily*

14. Have you ever induced vomiting after a meal?

- ☐ *never*
- ☐ *yes, rarely*
- ☐ *yes, sometimes*
- ☐ *yes, often*
- ☐ *yes, always*

15. Are you afraid that you will not be able to stop eating once you started?

- ☐ *no*
- ☐ *yes*

16. Have you ever visited a doctor or a hospital due to your eating disorder?

- ☐ *no*
- ☐ *yes:* _____

17. Have you previously been treated for your eating disorder?

- ☐ *no*
- ☐ *yes, where and for how long:*

_____

_____

18. Freedom of choice for treatment alternatives

- ☐ *While I know that there are other forms of treatments available for eating disorders, I have chosen the Mandometer® method.*

19. Is there anything else about your situation which we should be aware of?